

PATIENT QUESTIONNAIRE

CONFIDENTIAL

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

DENTAL HISTORY

- | | | |
|---|---|---|
| 1. Reason for visit: _____ | | |
| 2. When was your last dental visit? _____ | | |
| 3. How often do you brush your teeth? _____ | | |
| 4. What texture brush do you use? <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard | | |
| | YES NO | YES NO |
| 5. Do your gums bleed while brushing? | <input type="checkbox"/> <input type="checkbox"/> | |
| 6. Do your gums bleed when flossing? | <input type="checkbox"/> <input type="checkbox"/> | |
| 7. Do you feel pain to any of your teeth when brushing or flossing them? | <input type="checkbox"/> <input type="checkbox"/> | |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | <input type="checkbox"/> <input type="checkbox"/> | |
| 9. Have you noticed any loosening of your teeth? | <input type="checkbox"/> <input type="checkbox"/> | |
| 10. Does food tend to become caught between your teeth? | <input type="checkbox"/> <input type="checkbox"/> | |
| 11. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> <input type="checkbox"/> | |
| 12. Have you ever experienced any of the following problems in your jaw? | | |
| a. Clicking? | <input type="checkbox"/> <input type="checkbox"/> | |
| b. Pain (joint, ear, side of face)? | <input type="checkbox"/> <input type="checkbox"/> | |
| c. Difficulty in opening or closing? | <input type="checkbox"/> <input type="checkbox"/> | |
| d. Difficulty in chewing? | <input type="checkbox"/> <input type="checkbox"/> | |
| 13. Have you had any head, neck, or jaw injuries? | | <input type="checkbox"/> <input type="checkbox"/> |
| 14. Do you have frequent headaches? | | <input type="checkbox"/> <input type="checkbox"/> |
| 15. Do you clench or grind your teeth while awake or asleep? | | <input type="checkbox"/> <input type="checkbox"/> |
| 16. Do you bite your lips or cheeks frequently? | | <input type="checkbox"/> <input type="checkbox"/> |
| 17. Have you ever had: | | |
| a. Orthodontic treatment (braces)? | | <input type="checkbox"/> <input type="checkbox"/> |
| b. Oral surgery? | | <input type="checkbox"/> <input type="checkbox"/> |
| c. Gum treatment? | | <input type="checkbox"/> <input type="checkbox"/> |
| d. Your teeth ground or the bite adjusted? | | <input type="checkbox"/> <input type="checkbox"/> |
| e. Worn a bite plane or other appliance? | | <input type="checkbox"/> <input type="checkbox"/> |
| 18. Are you satisfied with the appearance of your teeth? | | <input type="checkbox"/> <input type="checkbox"/> |
| 19. Have you ever had an upsetting experience in the dental office? | | <input type="checkbox"/> <input type="checkbox"/> |
| 20. Is there anything about having dental treatment that bothers you? | | <input type="checkbox"/> <input type="checkbox"/> |

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | | | |
|--|---|---|--------|
| | YES NO | | YES NO |
| 1. Are you in good health? | <input type="checkbox"/> <input type="checkbox"/> | | |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> <input type="checkbox"/> | | |
| 3. Date of your last physical exam: _____ | | | |
| 4. Physician's name _____ | | | |
| Address _____ | | | |
| Phone No. _____ | | | |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> <input type="checkbox"/> | | |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> <input type="checkbox"/> | | |
| Please explain. _____ | | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? | <input type="checkbox"/> <input type="checkbox"/> | | |
| If yes, what medicine(s) are you taking? _____ | | | |
| | | | |
| 8. Have you had any abnormal bleeding? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 9. Do you bruise easily? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 10. Have you ever required a blood transfusion? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 11. Have you had a recent weight loss? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 12. Do you use tobacco? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 13. Do you use alcohol or cocaine or other drugs? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 14. Are you wearing contact lenses? | | <input type="checkbox"/> <input type="checkbox"/> | |
| 15. Do you have any disease, condition or problem not listed above that you think I should know about? | | <input type="checkbox"/> <input type="checkbox"/> | |

Women Only:

- | | |
|---|---|
| 1. Are you pregnant or think you may be pregnant? | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Are you nursing? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Are you taking birth control pills? | <input type="checkbox"/> <input type="checkbox"/> |

(OVER)

MEDICAL HISTORY CONTINUED...

Are you allergic to or have you had reactions to:

1. Local anesthetics like novocaine?
2. Penicillin or other antibiotics?
3. Sulfa drugs?
4. Barbiturates, sedatives or sleeping pills?
5. Aspirin?
6. Iodine?
7. Other?

YES NO



Do you have or have you ever had the following:

1. Rheumatic heart disease or rheumatic fever?
2. Scarlet fever?
3. Heart defect or heart murmur?
4. Heart trouble, heart attack, or angina?
 - A. Do you have pain in your chest upon exertion?
 - B. Are you ever short of breath after mild exercise?
 - C. Do your ankles swell?
 - D. Do you get short of breath when you lie down?
 - E. Do you require extra pillows when you sleep?
5. Pacemaker?
6. Heart surgery?
7. High blood pressure?
8. Low blood pressure?
9. Hepatitis, jaundice or liver disease?

10. Stroke?
11. Sinus trouble?
12. Lung or breathing problems?
13. Asthma or hay fever?
14. Hives or skin rash?
15. Fainting spells or seizures?
16. Diabetes?
17. AIDS or HIV infection?
18. Thyroid problems?
19. Allergies?
20. Arthritis or rheumatism?
21. Joint replacement or implant?
22. Stomach ulcer?
23. Kidney trouble?
24. Tuberculosis?
25. Persistent cough?
26. Cough that produces blood?
27. Cancer?
28. Sexually transmitted disease?
29. Epilepsy?
30. Anemia?
31. Leukemia?
32. Glaucoma?

YES NO

I certify that the information listed is complete and accurate.

SIGNATURE

(PATIENT, PARENT or GUARDIAN)

FOR COMPLETION BY THE DENTIST:

SUMMARY OF DENTAL HISTORY

SUMMARY OF MEDICAL HISTORY

MEDICAL HISTORY UPDATE:[illegible]